New Jersey Innovation Institute
An NJIT Corporation

2018 MIPS Reporting

Internal Medicine

Quality Reporting Requirements:

- Report on 6 quality measures or a specialty measure set
- Include at least ONE outcome or high-priority measure
- Report on patients of All-Payers (Medicare and Non-Medicare patients)

Specialty Measure Set (60):

- **001:** Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) – **Outcome, High Priority**
- **005:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **006:** Coronary Artery Disease (CAD): Antiplatelet Therapy
- **007:** Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)
- **008:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- **009:** Anti-Depressant Medication Management
- **024:** Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women Aged 50 Years and Older – **High Priority**
- **039:** Screening for Osteoporosis for Women Aged 65-85 Years of Age
- **047:** Care Plan – **High Priority**
- **048:** Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- **050:** Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – **High Priority**
- **091:** Acute Otitis Externa (AOE): Topical Therapy – **High Priority**
- **093:** Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use – **High Priority**
- **117:** Diabetes: Eye Exam
- **119:** Diabetes: Medical Attention for Nephropathy
- **126:** Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation
- **128:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
- **130:** Documentation of Current Medications in the Medical Record – **High Priority**
- **134:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- **154:** Falls: Risk Assessment – **High Priority**
- **155:** Falls: Plan of Care – **High Priority**

- **163:** Diabetes: Foot Exam
- **181:** Elder Maltreatment Screen and Follow-Up Plan – **High Priority**
- **204:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- **226:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- **238:** Use of High-Risk Medications in the Elderly – **High Priority**
- **243:** Cardiac Rehabilitation Patient Referral from an Outpatient Setting – **High Priority**
- **305:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- **309:** Cervical Cancer Screening
- **317:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- **326:** Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy
- **331:** Adult Sinusitis: Antibiotic Prescribed for Acute Viral Sinusitis (Overuse) – **High Priority**
- **332:** Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin With or Without Clavulanate Prescribed for Patients with Acute Bacterial Sinusitis (Appropriate Use) – **High Priority**
- **333:** Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse) – **High Priority**
- **334:** Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse) – **High Priority**
- **337:** Psoriasis: Tuberculosis (TB) Prevention for Patients with Psoriasis, Psoriatic Arthritis and Rheumatoid Arthritis Patients on a Biological Immune Response Modifier
- **338:** HIV Viral Load Suppression – **Outcome, High Priority**
- **342:** Pain Brought Under Control Within 48 Hours – **Outcome, High Priority**
- **370:** Depression Remission at Twelve Months – **Outcome, High Priority**
- **371:** Depression Utilization of the PHQ-9 Tool
- **373:** Hypertension: Improvement in Blood Pressure – **Outcome, High Priority**
- **374:** Closing the Referral Loop: Receipt of Specialist Report – **High Priority**
- **377:** Functional Status Assessments for Congestive Heart Failure – **High Priority**
- **383:** Adherence to Antipsychotic Medications For Individuals with Schizophrenia – **Outcome, High Priority**
- **387:** Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users
- **398:** Optimal Asthma Control – **Outcome, High Priority**
- **400:** One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk
- **401:** Hepatitis C: Screening for Hepatocellular Carcinoma (HCC) in Patients with Cirrhosis
- **402:** Tobacco Use and Help with Quitting Among Adolescents
- **408:** Opioid Therapy Follow-up Evaluation
- **412:** Documentation of Signed Opioid Treatment Agreement
- **414:** Evaluation or Interview for Risk of Opioid Misuse
- **418:** Osteoporosis Management in Women Who Had a Fracture
- **431:** Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- **438:** Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- **441:** Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
- **442:** Persistence of Beta-Blocker Treatment After a Heart Attack
- **443:** Non-Recommended Cervical Cancer Screening in Adolescent Females – **High Priority**
- **444:** Medication Management for People with Asthma – **High Priority**
- **447:** Chlamydia Screening and Follow Up

Additional Measures:

- **012:** Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- **066:** Appropriate Testing for Children with Pharyngitis – **High Priority**
- **109:** Osteoarthritis (OA): Function and Pain Assessment – **High Priority**
- **110:** Preventive Care and Screening: Influenza Immunization
- **111:** Pneumococcal Vaccination Status for Older Adults
- **112:** Breast Cancer Screening
- **113:** Colorectal Cancer Screening
- **116:** Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis – **High Priority**
- **236:** Controlling High Blood Pressure – **Outcome, High Priority**

Promoting Interoperability (PI) Reporting Requirements:

- Report on ALL required base measure to earn any credit for PI
- To satisfy base score requirements, clinicians must submit a numerator of at least 1 or answer Yes
- Report on additional performance measures or bonus measure to increase your PI Score

PI Base Score Measures:

PI Objectives and Measure Set (2015 CEHRT)	2018 PI Transition Objectives and Measure Set (2014 or 2015 CEHRT)
○ Security Risk Analysis ○ e-Prescribing* ○ Provide Patient Access ○ Send a Summary of Care* ○ Request/Accept Summary of Care*	○ Security Risk Analysis ○ e-Prescribing* ○ Provide Patient Access ○ Health Information Exchange*

*Exclusion available for measure if denominator is less than 100 patients or occurrences

Improvement Activities (IA) Reporting Requirements:

- Attest to up to 4 activities for a minimum of 90 days
- Choose one of the following combinations:
  - 2 High Weighted Activities
  - 1 High Weighted Activity and 2 Medium Weighted Activates
  - 4 Medium Weighted Activities

Medium Weighted:

- Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop – **EHR Bonus**
- Implementation of documentation improvements for practice/process improvements
- Collection and use of patient experience and satisfaction data on access
- Implementation of medication management practice improvements – **EHR Bonus**
- Annual registration in the Prescription Drug Monitoring Program
- Engagement of patients through implementation of improvements in patient portal – **EHR Bonus**
- Implementation of improvements that contribute to more timely communication of test results
- Use of certified EHR to capture patient reported outcomes – **EHR Bonus**
- Regularly assess the patient experience of care through surveys, advisory councils and/or other mechanisms.
- Engagement of Patients, Family, and Caregivers in Developing a Plan of Care – **EHR Bonus**
- Use group visits for common chronic conditions (e.g., diabetes).
- Implementation of condition-specific chronic disease self-management support programs
- Improved Practices that Engage Patients Pre-Visit
- Care coordination agreements that promote improvements in patient tracking across settings
- Chronic Care and Preventative Care Management for Empaneled Patients – **EHR Bonus**
- Practice Improvements for Bilateral Exchange of Patient Information – **EHR Bonus**
- Implementation of practices/processes for developing regular individual care plans – **EHR Bonus**
- Use of telehealth services that expand practice access
- Completion of training and receipt of approved waiver for provision opioid medication-assisted treatments
- Measurement and Improvement at the Practice and Panel Level

High Weighted:

- Participation in Systematic Anticoagulation Program
- Anticoagulant Management Improvements – **EHR Bonus**
- Glycemic management services – **EHR Bonus**
- Use of QCDR for feedback reports that incorporate population health
- Engagement of New Medicaid Patients and Follow-up
- Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
- Engage Patients and Families to Guide Improvement in the System of Care – **EHR Bonus**
- Participation in the CMS Transforming Clinical Practice Initiative
- Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record – **EHR Bonus**
- Consultation of the Prescription Drug Monitoring Program

Cost Reporting:

- CMS calculate Cost measures using administrative claims data if a clinician or group meets the cases minimum for attributed patients
- Individuals and Groups are not required to SUBMIT any additional information for the cost category

Cost Measures:

Medicare Spending Per Beneficiary (MSPB):

- The Medicare Spending per Beneficiary (MSPB) clinician measure assesses the cost to Medicare of services performed by an individual clinician during an MSPB episode, which comprises the period immediately prior to, during, and following a patient's hospital stay.

Total Per Capita Costs for All Attributed Beneficiaries (TPCC):

- The Total Per Capita Costs for All Attributed Beneficiaries (TPCC) measure is a payment-standardized, annualized, risk-adjusted, and specialty-adjusted measure that evaluates the overall cost of care provided to beneficiaries attributed to clinicians, as identified by a unique Taxpayer Identification Number/National Provider Identifier (TIN-NPI).